Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 136

Year: 2019

Inspection Report

Year:	2019
Name of Organisation:	Positive Care Ltd
Registered Capacity:	Three young people
Type of Inspection:	Announced
Date of Inspection	13th & 14th November 2019
Registration Status:	Registered without attached conditions 30th May 2018 to 30th May 2021
Inspection Team:	Eileen Woods Linda McGuinness
Date Report Issued:	10th January 2020

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met :** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

TÚSLA An Ghníomhaireacht um Leanaí agus an Teaghlach Child and Family Agency

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 30th of May 2018. At the time of this inspection the centre was in its first registration and was in year two of the cycle. The centre was registered without attached conditions from the 30th of May 2018 and 30th of May 2021.

The centre was registered to provide medium to long term care for up to three young people through a care framework that addresses trauma and attachment from pre-admission/admission risk assessment, stabilisation and planning, support and relationship building and positive exits. There were two children living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
3: Safe Care and Support	3.1, 3.2, 3.3
5: Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4

Inspectors looked closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and the relevant social work departments on the 18th of December 2019. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 20th of December 2019. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 136 without attached conditions from the 30th of May 2018 to the 30th of May 2021 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

Inspectors reviewed the child protection policies in place and found these to be compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017. The organisation had invested significantly in producing polices and flow charts that were organised into dedicated a child protection folder at the centre. The staff had easy access to the folder and several referred to it as a daily working tool. The centre also had an appropriate child safeguarding statement/CSS and confirmed that they had a letter of compliance from the Tusla Child Safeguarding Statement Compliance Unit. The CSS was displayed at the centre and the young people had been made aware of it. The CSS was in its ninth version having been updated for policy additions, national guidelines and changes in personnel. The version available was up to date regarding the newly appointed person in charge, in this instance this was the manager of the centre. The named designated liaison person/DLP was the regional manager in line with the organisations policy and procedures on child protection. The centre also had policies on whistle blowing, lone working, anti-bullying policy and arrangements were in place to inform parents of allegations of abuse.

A system of recording and tracking to inform reasonable grounds for concern has been introduced and was being well managed by the team. The young people were kept informed when a concern arose and any actions taken were discussed with the young people, their social workers and where possible their parents or guardians. There was evidence in key working and in one to one work of the team discussing safe decision making with young people and working in a planned way to assist them in better protecting themselves and others.

Specialist safeguarding referrals were pursued where required but inspectors found that significant delays from the Tusla social work departments involved had resulted in slow progress toward the vital external interventions. Both young people's care plans were lacking detail in all aspects of the written plans and this had the result of not outlining clearly what the social work department's decisions and expectations were in this aspect of the work. The centre had proceeded with identifying areas of

vulnerability from pre-admission onward and individual safety plans, risk assessments and general planning reflected actions relevant to the young people's risks.

The staff team had received training in child protection when inducted into the organisation before commencing work in the centre. The inspectors recommend that standalone child protection and safeguarding training be developed and delivered to staff with a renewal schedule devised for this. The staff team were relatively inexperienced and therefore undergoing a high rate of continuous learning, it would be advisable for them to have a separate opportunity to attend training. The centre had also organised team training in recognising and responding to child sexual exploitation. The team meetings and supervisions addressed ongoing child protection work.

Compliance with the child protection policies and procedures was audited by the regional manager/RM and overseen through the audit outcomes by the client services manager/CSM. Inspectors found that the audits also took account of complaints, young people's rights, lone working and risk assessments. The most recent three audits were positive in their assessment of the progress of the team in this aspect of their work.

Inspectors found that as is the policy of the company that records were archived on a six monthly rotation, we recommend that concerns not be archived to allow for good tracking through to outcomes.

Standard 3.2

The organisation has a therapeutic care framework based on attachment and trauma informed care. All staff was trained in the frame work and refreshers were delivered yearly. The organisation had a clinical department allowing access for the team to a clinical psychologist to inform the implementation of the framework and to seek advice. The psychologist also developed therapeutic plans for the young people. Due to a change in appointed persons the therapeutic plans had gaps in review but had recently been updated. Inspectors found that the therapeutic plans were not fully integrated into the core work at the centre as a working tool as yet but did find that the care framework tools was being actively implemented in the day to day work. The management supported this primarily through supervision and through daily guidance. Inspectors found that due to roster changes aimed at compliance with the

European working time directive (EWTD) that verbal handovers were brief and that team meetings were not rostered for and therefore poorly attended.
The tools and interventions within the care framework were being implemented with a focus on positive behaviour support and this was evident on the young people's placement plans and in their key working records. The young people in chatting with the inspectors were happy with their experience at the centre. They presented as comfortable in the house, considered it their home and were welcoming to the inspectors during our visit.

Staff were also trained in a recognised method of crisis management and operated in accordance with this when dealing with incidents and their aftermath. There was information on the young people social and care history and professional assessment available to staff to inform their work. There were therapeutic plans, safety plans and crisis management plans to act as wraparound supports for the young people. The young people could nominate a key worker that they would like to work with and were supported to raise comments or complaints where they had concerns. The work related to behaviour management and the implementation of the care framework in a positive context was audited through the RM work.

There were no restrictive practices in place at the time of the inspection. There was a policy in place on the use of sanctions and the goal the management stated was to engage in positive behaviour support through related rewards for same. The latter were evident increasingly on file but inspectors also found that there were sanctions in place that would benefit from review with the clinical team, the social worker and the young person to examine if they were the most appropriate fit for overarching goals.

Standard 3.3

Inspectors found that the young people had been supported to openly report and record any concerns they had regarding their experiences at the centre and externally. They were found to have been responded to well and clearly in a timely manner. Their social workers and family were aware of these as well as any incidents as were the RM and the CSM. The monthly audits reviewed the actions and outcomes and records were available on file of any complaints and concerns raised. Inspectors recommended the addition of an 'upheld or not' comment on the complaint forms and also to improve the cross reference aspect to ensure that all the actions taken were clearly combined for the records.

There was evidence of the significant event reporting taking place in accordance with the policy and these were found to have been sent in a timely manner to the relevant persons. They were also entered into a suitable register thereafter. There was evidence of follow up with the young people, consultation and discussions were recorded. There was action taken involving negotiation and mediation adding to the life skills and learning from outcomes for the young people. There were crisis management plans and these were updated following events, there were also absence management plans that were similarly reviewed in accordance with their relevant protocols. All plans were shared with the social workers for feedback and signing. There was evidence of interdisciplinary communication and co-operation with professionals meetings being convened and recorded where required.

Inspectors found that following changes to the weekly senior team meeting and the monthly regional management meeting that a significant events review mechanism was not as defined as it had been previously, the RM advised that they and the CSM had identified this as a gap and had plans in place to address this from January 2020 onward.

Compliance with Regulation	
Regulation met	**Regulation 16**

Compliance with standards	
Practices met the required standard	**Standard 3.1** **Standard 3.3** **Standard 3.2**
Practices met the required standard in some respects only	**None identified**
Practices did not meet the required standard	**None identified**

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The registered proprietors of this company had established an organisational structure which identified roles at all levels with specific responsibilities for the management of care delivery in compliance with the national standards, the relevant regulations and legislation. The policies and procedures, information to and from

young people and staff literature including access to resources were all up to date and in place in hard copy as well as digital for all to access.

Staff in the centre demonstrated a clear knowledge of the company structure, its purpose and their role within in. They knew who to contact and how from the different departments within the company. Alongside the operational line management the additional departments within the company were clinical, maintenance, HR/recruitment, IT, training and finance. There was evidence that the new manager was overseeing staff working within policies and procedures appropriately. The staff no longer had access to a dedicated handover meeting and team meeting attendance had declined and this must be addressed by the centre management to ensure good quality ongoing sharing of information.

Standard 5.2

Inspectors found evidence that the organisational map was accurate and that the persons identified in the roles were delivering support, oversight and structured compliance systems designed to deliver good quality care to young people. There were records of meetings at all levels, audits, reviews and outcomes available for inspectors to review. Leadership through decision making, communication, training and review was evident. There had been changes at several levels during 2019 with the CSM remaining the consistent person in post; they maintained leadership and communication systems in place throughout. The registered proprietors completed service level agreement negotiations with Tusla.

At the time of this inspection the centre was open 17 months and the recently appointed manager was the person in charge. The manager had been the deputy manager for the centre prior to taking up the manager post one month ago. They were suitably qualified and experienced for the role. There was also a deputy manager in post. Although newly in post they had been displaying leadership and direction for the team supported by the regional manager and the client services manager. Training in managing people had been provided by the company and there was a record of delegation of tasks and to whom. All supervision was taking place in accordance with the policy guidelines, was reflective of the planning for young people and was subject to audit for accountability.

Inspectors found that there was a well maintained quality and compliance folder in which the management maintained records of all meetings, decisions, audits and actions. There were IT processes to support tracking and alerts, for example, for staff

training. The external senior team had access to all records in real time. The manager completed weekly and monthly reports of good quality, there were monthly RM audits and daily contact of a good standard and monthly regional managers meetings took place. The monthly meetings were clearly recorded and relevant to the work. There were centre specific weekly maybe online calls with the RM, CSM and the management; these were also recorded as clear and effective. Although located at a distance from the main offices of the organisation the centre was visited regularly by the RM, the CSM and the Psychologist.

The inspectors found through the interviews and the questionnaires submitted that the team were working toward a common goal of making a positive difference in young people's lives and that they identified their policies and the leadership as central to this.

There was a risk management framework and policy operational within the organisation which provides for risk assessment, analysis and planning throughout a placement. Current and ongoing risks were tracked by the RM to the centre manager and the team through audits and the team meetings. Inspectors identified that although the system was well structured and recorded and there was a categorisation of presenting risks for both individual and the group impact at the pre admission stage of referral. This risk assessment framework would benefit from an extra column to assess if proposed risk management measures were likely to reduce identified risks. This could further inform safe admissions and also be analysed to inform on-going risk review.

There was an organisation risk register and a centre risk register in place. The register at the centre related substantially to health and safety. The inspectors were informed that there was a proposal agreed for significant expansion of the risk policy and the risk register to include safety plans, risk assessments, crisis plans and so forth from January 2020.

The young people's files contained individualised risk assessment and safety plans, these were evidenced as congruent and consistent with the young people's comments and needs. Inspectors found that the staff acted on the risks according to the key work records and the daily log. There were outstanding areas of risk that the inspector's recommended that the team remain vigilant around regarding self harm and related to medication. When these items were raised during the inspection immediate action was taken by the centre manager and the RM and relayed back to inspectors.

Standard 5.3

The centre had a statement of purpose and function that stated the capacity of three young people aged thirteen to seventeen for medium to long term care. This purpose and function was delivered through a care framework based on established models of care for attachment and trauma approaches to care of young people. The team had all been trained in the framework or had commenced this training and they were familiar with the statement of purpose and function which was displayed within the centre. The statement of purpose was included in information for young people, for professionals and for families and guardians.

At the time of their last inspection in 2018 the centre was found to have breached their purpose and function with the provision of short term placements. The action plan/CAPA submitted to the inspectorate in 2018 committed to ensuring that there would be sufficient gate keeping regarding placements. Inspectors found through the centre register that another short term placement had taken place for a young person aged over seventeen in 2019. The registered proprietor must take further action to ensure that there is full compliance with the stated purpose and function. The young person who was admitted was in continual crisis and this was not without significant impact on the young people already resident. The staff team and young people had to adapt to a different set of demands and daily experiences. At the time the other two young people complained about feeling unsafe and this was acted upon within the centre by the previous manager. There was no evidence subsequently of this being formally reviewed by internal or external management for learning purposes and to inform future decision making.

The young people were provided with information regarding the centre, they had admissions meetings and their rights regarding advocacy, information and support were represented throughout the records at the centre. Both young people presented as settled in the centre and expressed that they were happy at present with how things were. They were given a booklet, a young person's version of the purpose and function and a young person's copy of the national standards.

Standard 5.4

Inspectors did, as outlined, find an organisation with quality assurance and continual development at its core. Systems were in place and refined in response to review. There were schedules in place for policy review and updates, meetings and auditing.

This was an ongoing development process given the introduction of new national standards, newly appointed persons in roles and the expansion of the service. Inspectors found that quantitative analysis was increasingly being integrated with a focus now on qualitative analysis of the impact of the model of care for the young people, for positive behaviour support and regarding outcomes.

A review and analysis of the purpose and function must now take place, as stated, to ensure that there are safeguards in place to maintain and build on stability for the young people.

Compliance with Regulation	
Regulation met	**Regulation 5**
Regulation met	**Regulation 6.2** **Regulation 6.1**

Compliance with standards	
Practices met the required standard	**Standard 5.1** **Standard 5.2** **Standard 5.4**
Practices met the required standard in some respects only	**Standard 5.3**
Practices did not meet the required standard	**None identified**

Actions required

- The registered proprietors and management must review and evaluate the statement of purpose and function, identify any non-compliance and take action to ensure that they do not recur.
- The centre manager must adhere to pre admission procedures that take account of the purpose and function of the centre.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The registered proprietors and management must review and evaluate the statement of purpose and function, identify any non-compliance and take action to ensure that they do not recur. The centre manager must adhere to pre admission procedures that take account of the purpose and function of the centre.	Purpose and function of the unit is taken into consideration and any referrals accepted going forward will be within the statement and purpose. Centre management only accepting referrals that match the purpose and function of the unit.	The registered proprietors and the operations management team will oversee and support implementation of these actions.